Sexually Transmitted Disease Screening Questionnaire

Patient Name:_____ Visit Date:___/__/____

Date of Birth: _____ Gender: M / F

1. What race do you consider yourself? (Check at least one, and all that apply).
   ___White/Caucasian ___Black/African American ___Native American/Alaskan native
   ___Asian ___ Hawaiian/Pacific Islander __Other race

2. Do you consider yourself of Hispanic ethnicity? ___Yes ___No

3. (Women only) Date last menstrual period began: _____
4. Have you ever been treated for an STD? __Yes __No Type:_____When:_____
5. Are you allergic to any medications? If so, please list:_____
6. Have you had any of these symptoms recently? (check all that apply):

   ____Abnormal discharge/drip from vagina or penis
   ____Burning or pain when you urinate (pee)
   ____(Women Only) Pelvic pain
   ____(Women Only) Abnormal vaginal bleeding
   ____No symptoms

7. In the past 60 days, how many people have you had sex with(vaginal/oral/anal)?____
8. In the past 60 days, did you start having sex with someone new? ___Yes ___No
9. Do you have someone steady, like a boyfriend/girlfriend/spouse that you have sex with?
   ____Yes ____No (if you checked No, SKIP to Question 10)
   9a. In the last 6 months how often did you use condoms with this person?
   ____Always
   ____Usually (more than half of the time)
   ____Sometimes (Less than half the time)
   ____Never
   ____I did not have sex with my steady partner in the last 6 months.
   9b. did you use a condom the last time you had sex with this person? __Yes__No
10. In the last 6 months have you had sex with anyone else (besides a steady partner)? _____
    (If "No", skip the rest of the questions).
    10a. In the last 6 months how often did you use condoms with this person?
    ____Always
    ____Usually (more than half of the time)
    ____Sometimes (Less than half the time)
    ____Never
    ____I did not have sex with my steady partner in the last 6 months.
    10b. Did you use a condom the last time you had sex with them? ___Yes ___No

Clinician Signature_____ Date:_____

College of the Canyons
Student Health & Wellness Center
GYNECOLOGIC HISTORY

Name:_____ Date:_____
Age:_____ Date of Birth: _____ Country of Birth:_____
Date of Last Menstrual Cycle:_____
Current Address:
_____
_____
May we send test results to you at this address? Yes / No

History

Reason for health center visit:_____
Do you have PMS? (water retention, emotional changes, etc.)_____
Current birth control method:_____
Menstruation began at age ____ Periods: regular / irregular every ____days
Menstrual cramps?_____ Bleeding between periods? _____
Did your mother take DES when pregnant with you? Yes / No/ Don't know
Have you been taught breast self-exam?____Do you check yourself monthly?_____ How many pregnancies have you had?_____
Please list any chronic illnesses you have:_____
Do you smoke? _____ How many/day?_____
Do you live with a smoker?_____
Use alcohol?____ How many drinks/day or week?_____
Do you use recreational drugs?_____
Do you use herbal remedies/vitamins/other non-prescription meds?_____
Do you have a family history of: Breast Cancer_____ Diabetes_____ High Blood Pressure_____ Thyroid disease_____ Heart attack or stroke_____Asthma/allergies_____Other_____
When was your last mammogram?_____ Pap test?_____ Screening test for sexually transmitted infection_____Any abnormal tests?_____
Have you ever been abused, in your current or a past relationship?_____
When was your last dental exam? _____ Do you use a seatbelt?_____
Do you use sunscreen?____Do you have any skin problems?_____
When was your last Tetanus shot? _____ Measles vaccine?_____
Did you have chickenpox as a child?_____Are you on a diet?_____
What do you do for exercise?_____

College of the Canyons
Student Health & Wellness Center

MALE GENITO-URINARY HISTORY

Name:_____ Date:_____
Age:_____ Date of Birth: _____ Country of Birth:_____
Date of Last Menstrual Cycle:_____
Current Address:
_____
May we send test results to you at this address? Yes / No

History

Reason for health center visit:_____
Current birth control method:___ condoms___withdrawal ___depend on partner's birth control method_____other
Have you ever had unprotected sex? Yes / No
My sexual partners have been: male / female / both
Have you had, or do you currently have: ___abnormal penile discharge or drip ___burning pain when you urinate ___bumps or rash on penis or groin _
Did your mother take DES when pregnant with you? Yes / No/ Don't know
Have you been taught testicular self-exam?____Do you check yourself regularly?_____
Please list any chronic illnesses you have:_____
Do you use tobacco in any form? _____
Do you live with a smoker?_____
How many times in the past year have you had 5 or more alcoholic drinks in a day?_____
Do you use recreational drugs (marijuana/ecstasy/speed, etc)?_____
Do you use herbal remedies/vitamins/or non-prescription meds?_____
Do you have a family history of: Breast Cancer_____ Diabetes_____ High Blood Pressure_____ Thyroid disease_____ Heart attack or stroke_____Asthma/allergies_____Other_____
My last screening test for sexually transmitted infection was _____. Any abnormal results? _____
Have you ever been abused, in your current or a past relationship?_____
When was your last dental exam? _____ Do you use a seatbelt?_____
Do you use sunscreen?____Do you have any skin problems?_____
When was your last Tetanus shot? _____ Measles vaccine?_____
Did you have chickenpox as a child?_____Are you on a diet?_____
What do you do for exercise?_____